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ABSTRACT

This paper examines the moral presuppositions of public policy and professional practice concerned with the sexual victimization of children by adults. It begins with an overview of the problem of child sexual abuse and a set of 10 generalizations drawn from research on both clinical and non-clinical samples of victims. Three responsibilities which need to be undertaken by researchers and clinicians are proposed: (1) that they develop a better understanding of the moral-ideological background of current interest in the problem of child sexual abuse; (2) that they acknowledge those facts which might conflict with their own moral presuppositions and challenge those beliefs which impede a proper understanding of the victim; and (3) that they put the victim's needs and perceptions at the head of their treatment priorities, thereby challenging themselves to be more critical of their professional response to reports of child sexual abuse. Research is reviewed in the areas of moral-ideological background, the question of harm, treatment issues, and implications for moral theory. The report concludes that professionals who work with victims of child sexual abuse must respect the personhood of the child as a moral absolute, must always work to minimize the harm which a child suffers from abuse, and must ensure that the child's opinions and perceptions of victimization are respected. (NB)

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Ethics and Therapeutics:
The Treatment of Victims of Child Sexual Abuse

by Michael and Judith M. Chiariello

The object of this paper is to examine the moral presuppositions of public policy and professional practice concerned with the sexual victimization of children by adults. The paper is a collaborative effort by a philosopher and a counselor who are interested in the way moral beliefs affect our work in the world. The philosopher's interest is a desire to improve our belief systems, while the counselor's concern is to improve treatment. We begin our discussion with an overview of the problem.

1. Scope of the Problem

Research results on sexual abuse of children are often contradictory. But one thing is clear -- the sexual victimization of children has been shown to be prevalent enough to constitute a significant social problem, one which has mobilized the medical, legal and mental health profession.

It is difficult to determine the actual number of sexually abused children in the United States. The incidence of sexual abuse may be greater than the incidence of physical abuse. National estimates gathered in 1969 by the American Humane Association indicate that each year there may be 4,000 sexual abuse cases in every large city (DeFrancis, 1969). Landis' 1956 study indicates that some form of childhood or adolescent sexual abuse may occur in as much as one third of the population. Gagnon and Simon (1970) estimated that 500,000 female children, from the ages of four to thirteen, are sexually victimized annually, including 20-25% of middle-class children and 33-40% of children raised in lower-class environments. Kinsey's research (1953), culled from a non-clinical, general population, involved a finding that 24% of all females are molested as children.

The National Incidence Study (National Center for Child Abuse and Neglect, 1981) examined a random sample of 26 U.S. counties and tried to count all the cases that came to the attention of child protection agencies as well as other professionals. This study estimated that 44,700 children were sexually abused in the year starting May 1, 1979, equivalent to an incidence rate of 0.7 per 1,000 children (in Finkelhor, 1986).

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Prevalence studies give us rates ranging from 6% to 62% for females and from 3% to 31% for males, depending on the type of sample involved, the definition of sexual abuse used and the kind of interview conducted (Finkelhor, 1986).

From a review of studies of clinical and non-clinical samples, we may make the following generalizations:

1. Sexually abused children can range in age from infancy to adulthood, with the most common age range being 8 to 12 (Gagnon and Simon, 1970).
2. Among reported cases, female victims outnumbered males ten to one (De Vine, 1980).
3. Studies on non-clinical populations (Landis, 1956; Schultz, 1980) show that sexual abuse of males is more widespread than case reports would indicate.
4. Types of offenses against children include exhibitionism, fondling, genital contact and intercourse, with only about 10% of cases involving penetration (De Vine, 1980).
5. At least half, and possibly as many as 80% of all child victims were sexually abused by people known to them (De Vine, 1980).
6. Force rarely is necessary to involve a child in sexual activity (De Vine, 1980).
7. Research has not been able to turn up any conclusive findings on the long-term psychological damage of childhood sexual experiences (De Vine, 1980).
8. The families of sexual abuse victims usually exhibit several areas of dysfunction (DeFrancis, 1969).
9. There is no significant difference between the frequency of sexual abuse incidents in rural and urban areas (Schultz and Jones, 1983).
10. There is an estimated ten to one ratio of unreported to reported cases (De Vine, 1980).

Our knowledge of the impact of sexual offenses against children is limited because much or our data on victims comes from those reported cases which may be an atypical sample of the victim population. The reliance on reported cases involves alternative response frameworks, such as police, hospital emergency rooms and child welfare agencies. Therefore, data may bear the influence of different intervention priorities. Secondly such a population will include the most serious victims, from the point of view of physical injury, and those exhibiting publicly obvious behavior disorders (truancy, runaway, etc.), as well as victims of assaults by strangers, and perhaps neglects those victims for whom the damage is less severe than our intuitions would lead us to suspect. If the abuse has been

commited by a relative or friend, the intervention involves an understanding of the ambivalent feelings which may be present in the victim, as well as a supportive treatment plan for the entire family. The important point here is that a reporting population is subject to a variety of post-offense traumas generated by the medical, legal and child welfare procedures set in motion by the report.

In light of, and in response to, the contradictory and confusing research outcomes with respect to both the incidence and the impact of child sexual abuse, we propose three responsibilities, or tasks, which need to be undertaken by researchers and clinicians. These will be referred to throughout as R_1, R_2 and R_3.

R_1: We need to develop a better understanding of the moral-ideological background of current interest in the problem. This will enable us to minimize any bias which impedes objective understanding of the problem and which would disserve the victim.

R_2: We need to acknowledge those facts which might conflict with our moral presuppositions, and challenge those beliefs which impede a proper understanding of the victim and her needs.

R_3: Putting the victim's needs and perceptions at the head of our treatment priorities challenges us to be more critical of our professional response to reports of child sexual abuse.

2. Moral-Ideological Background

The data cited above show that, while sexual abuse and molestation of children is occuring with significant frequency, research and documentation of certain aspects of the problem remain sketchy. Even more than most areas of research, child sexual abuse is fraught with the moral or ideological bias of investigators. This is not surprising, since both subjects, children and sexuality, are sensitive ones in our society. Any undertaking which brings together children and sex in the same discussion is bound to be controversial. Although we are more enlightened on the subject today than at any time in the past, integrating recent research findings with an enlightened therapeutic perspective remains a task for all of us involved in providing services to children and their families.

Central in the history of the treatment of childhood sexual victimization is Freud, who brought the subject out of Victorian secrecy into open scientific discussion. However, Freud's analysis stands as the classic example of denial of the reality of incest. In his 1897 letter to Fliess, Freud discusses his disbelief of the reports of his female patients: "Then there was the astonishing thing that in every case blame was laid on perverse acts by the father, and realization of the unexpected frequency of hysteria, in every case of which the same thing applied, though it was hardly credible that perverted acts against children were so general" (Herman and Hirschman, 1977).

In a now famous reversal, Freud concluded that his patients were reporting fantasies. One can only speculate on the degree to which Freud was influenced by political and societal pressures in his reformulation of childhood sexuality theory. This belief that the accounts he heard from his patients were fantasies, not true experiences, led Freud to the formulation of the Oedial Complex. His theory promoted two negative developments in the study and treatment of sexual abuse victims: (1) denial and (2) blaming the victim. (1) Therapists trained in Freudian principles of psychoanalysis discounted patients' reports of childhood sexual victimization. As a consequence, several generations of women who reported such experiences in psychotherapy have found themselves contradicted and discounted by their therapists. (2) Freud's theory encouraged shifting blame from the adult to the child. Even actual experiences could now be attributed to the child's Oedipal impulses, rather than the adult's sexual impulses. Any moral opprobrium was placed squarely on the victim.

Kinsey was another important figure in the history of research on child sexuality. In spite of evidence from his survey that child molesting, sexual abuse and incest were far more widespread than had previously been shown, he gave these findings very little attention. Most of the childhood sexual experiences in Kinsey's population involved encounters with fondling and exhibitionism. Kinsey stated ". . .it is difficult to understand why a child, except for its cultural conditioning, should be disturbed at having its genitals touched, or disturbed at seeing the genitalia of other persons" (in Shultz, 1980). In fact, most of the women who reported such contacts in Kinsey's sample did not appear to suffer any long-term consequences. Kinsey, writing in a period of zealous sexual reform, may have been influenced to select and analyze those data which would help to liberalize legislation governing private sexual activity and to minimize those findings which might impede reform.

Yet another approach to the study of child sexual abuse has been taken by feminist theory, which holds that sexual victimization may be as common as it is in our society because of the degree of male supremacy. According to Brownmiller (1975), sexual victimization and its threat are useful in keeping women intimidated and maintaining male dominance. Certainly, in a male-dominated society, the sexual exploitation of women and children is made easier. For example, if family members are regarded as possessions, men can take liberties with them. The view of the male sexual urge as overpowering gives a certain degree of acceptability to male antisocial behavior, such as sexual abuse. Feminist theorists argue further that the incest taboo may have a different meaning for the two sexes. Because the incest taboo is an agreement among men regarding sexual access to women, it may be more easily and frequently violated by men.

Another faction which has made its voice heard in recent years (Constantine and others, 1980) is one which champions the sexual rights of children. This movement takes the radical perspective that children are by nature sexual and capable of giving "informed consent" for voluntary sexual contact. Proponents of this view rest much of their case on the fact that sexual contact between children and adults is not categorically a harmful experience. It is true that research has produced no definitive conclusions on the question of harm. We will turn to that question below.

The four perspectives outlined above may help to illustrate the difficulties faced by service providers and researchers who must approach with sensitivity and objectivity the client who is a sexual abuse victim. We need to acknowledge those facts which might conflict with our presuppositions and challenge those beliefs which impede a proper understanding of the victim's needs ($\mathbf{R_2}$). Putting the victim's needs and perceptions at the head of our treatment priorities challenges us to be more critical of our professional response to reports of child sexual abuse ($\mathbf{R_3}$).

3. The Question of Harm.

A review of the research indicates that professionals do not agree on any of the effects of sexual abuse on children. As the historical examples given above show, effects of sexual victimization reported in the literature may reflect the world view of the period ($\mathbf{R_1}$). Since no more than 5 - 10% of sexual abuse involves physical injury (Schultz, 1980), the presumed trauma would seem to be psychological or social. It may be useful for professionals to assume the absence of trauma unless the evidence clearly indicates otherwise. What the belief in trauma does is to pit the professional against

the child and her/his family, who may feel otherwise (R_2). The risk is that a type of self-fulfilling prophecy develops. We are now at risk of iatrogenic trauma, where the helping process is useless or actually damaging, managing to produce the problem it claims to abhor but which it, in fact, must show to be real in order to sustain the ideology upon which it is based (R_3).

In many cases child victims are forced to take what may be "a short-lived, distasteful act (in the child's mind) . . . and blow it all out of proportion, forcing the child to reorient his ideas to the confused adult interpretation of the event" (Schultz, 1980, p. 41). In addition the child's role as prosecution witness in the law enforcement process may produce more trauma than the original incident. (Ibid.) Mental health and hospital personnel may unwittingly ascribe more negative meaning to the event than the child does.

Burgess and Holmstrom's data (1974) matched that of Gagnon and Simon (1970) who discussed social network reactions to child sexual abuse cases and stated that these may further complicate the child's reaction. Their data clearly indicated that a syndrome of symptom reaction is the result of pressure to keep the activity secret as well as the result of disclosure.

In a study of incest, Summit and Kryso (1978) state, "In our experience, the harm observed from incestuous encounters correlates not so much with the forcefulness or the perversity of the encounter as with the climate of the environmental response."

In Schultz and Jones' study (1983), based on solicited reports from a general college population, respondents' retrospective evaluations of sexual acts were less frequently negative than might be expected. An interesting finding in this survey was that 34% of females recalled early sexual acts as negative, while 1.7% of males recalled them as negative, suggesting that sexual socialization of males lead them to view such experiences as initiation, while females may view them as violation.

Finally, children have only a dim sense of adult sexuality. What may seem like a horrible violation of social taboos from an adult perspective need not be so to a child. A sexual experience with an adult may be something unusual, vaguely unpleasant, even traumatic at the moment, but not necessarily a crisis with long-lasting negative consequences. Most of the women in Kinsey's sample did not appear to suffer any long term consequences. Landis' survey (1956) and several other case studies (Bender and Grugett, 1952; Yorukoglu and Kemph, 1966) have also found children to be relatively unscathed. Bender and Blau (1937) reported 16 case studies of child sex victims who underwent psychiatric examinations after reporting: "The emotional reaction of these children was in marked contrast to that

manifested in the same situation by their adult guardians, which was one of horrified anxiety and apprehensiveness regarding the future of the child."

On the other hand, there is no lack of reports of traumatic outcomes of early sexual experiences. Burgess and Holmstrom (1974) reported that children victims seen in hospital emergency rooms seem to suffer many of the same severe consequences as do adult rape victims. There is confusion, crying, depression and subsequently a sense of shame, guilt and awareness of stigma. (One must question here intrusive emergency room procedures and the fact that the most serious cases are brought to emergency rooms).

Clinical records from psychotherapy on adults who were former child victims note that women with such experiences appear in high numbers among their clients and are often suffering depression and difficulty in relating to men (Henderson, 1972; Herman and Hirschman, 1977; Molnar and Cameron, 1975). Again, one must take into account that therapists are seeing an atypical population -- those who do suffer from long-term consequences.

In a study of long-term effects, Tsai , Feldman-Summers and Edgar (1979) found feelings of guilt and depression, negative self-image, and problems in interpersonal relationships. Sloane and Karpinski (1942) who studied five cases of incest, found that "only one of the five girls could be said to have worked out a satisfactory adjustment, while the others manifested varous degrees of distortion."

In 1984, the Tufts New England Medical Center gathered data on families involved in a treatment program restricted to children who had been victimized or revealed their victimization in the prior 6 months (Finkelhor, 1986). Standardized measures were used so that characteristics of sexually abused children could be contrasted with general and psychiatric populations. Tufts researchers found differences in the amount of pathology reported for different age groups. Of the 4-6 year olds in the study, 17% met the criteria for "clinically significant pathology," demonstrating more overall disturbance than a normal population but less than the norms for other children their age who were in psychiatric care. The highest incidence of psychopathology was found in the 7-13 year old age group, with 40% scoring in the seriously disturbed range.

Studies of specific deviant groups reveal frequent experiences of sexual abuse in the histories of these people. A large proportion of female drug addicts (Benward and Densen-Gerber, 1975) and prostitutes (James and Meyerding, 1977) were found to have incest in their backgrounds.

4. Treatment Issues.

Given all of these conflicting findings, how do we, as professional helpers, develop a treatment model that is both helpful and ethically sound? One thing is clear: sexual behavior between adult and child is neither always harmful nor always harmless. Just as clear is the fact that once a case is reported and indicated, other factors begin to influence the child's perception of the event.

Counselors and therapists constitute one of those factors and we must continuously work at exploring our own feelings concerning childhood sexuality. It is necessary to generate a warm, accepting milieu before productive therapeutic transactions with victims can begin. This may involve confronting our own revulsion and anger, so as not to project these feelings onto the client. As one therapist stated, "I get angry <u>for</u> her. How can she <u>not</u> be angry with her father?" Getting angry for a client is not a very helpful or successful intervention. (Giaretto, 1976).

If we maintain a child-centered perspective, what may seem like a horrifying crisis to an adult may not have been for the victim. Children do not share adult meanings of sexuality. This last point is perhaps the most important to consider in our treatment of children who have been sexually abused. We are all expected to react severely to adult-child sexual encounters. Such a reaction is bound to insure the unlikelihood of victims escaping the difficulties produced by interpretation. What are needed are professional criteria to determine when the best interests of the child mandate intervention and when they do not. The impact of civic authorities on incestuous families, for example, commonly adds up to either rejection of the victim's plea for help or disruptive punishment for the entire family. It is evident that typical community intervention in incest cases, rather than being constructive, has a devastating effect on a family already weakened by serious internal stresses (Giarretto, 1976).

Again, the task is to develop a treatment model that is both helpful and morally unbiased. We want to say that child sexual abuse is always wrong, while we concede that it is not always harmful, and we want to say that intervening to protect children from sexual abuse is always right, while we concede that it may sometimes produce a greater harm.

5. Implications for Moral Theory

In our account we have emphasized three responsibilities which, we believe, require a re-examination of our moral belief systems. In this section we will sketch some theories from moral philosophy which may provide us with a framework for such an evaluation.

Let us be clear that our object is not to challenge or weaken the moral prohibitions which restrain adults and protect children from sexual victimization. What we seek is an improved moral understanding as a basis for improved treatment of children. It need not be said that our priority remains the well-being of the child.

If we were to ask what is the "wrong" of child abuse, moral philosophy would present two aproaches to the question in terms of what are called ***teleological*** and ***deontological*** ethics. The deontological approach asserts that wrongness is a quality inherent in certain actions regardless of context, intention or, most importantly, the outcome or consequences of the action. For example, deontologists will argue that if one has made a promise then it would be wrong to break it, even when that would produce more beneficial results. The other approach, teleological ethics, regards the consequences of an action as the source of its rightness or wrongness: broken promises usually promote bad results and are, therefore, wrong.

The most prevalent form of teleological ethics is called **utilitarianism** and was developed in the 19th century by British philosophers seeking a scientific basis for moral and social reform. What utilitarianism does is to adopt the teleological approach and specify empirically determinable facts as the relevant consequences to be considered in evaluating an action. In other words, teleology argues that an action is right if its results are good, wrong if its results are bad, and utilitarianism defines good and bad in terms of pleasure and pain, happiness and unhappiness.

This utilitarian approach is very attractive for a number of reasons, including these two: (1) By defining the morally relevant evidence as empirical, utilitarianism redefines ethics as a social science; and (2) utilitarianism allows us to separate the spheres of public and private morality, so essential in discussions of sexual morality, on the basis of who is affected by an action. Private effects are a matter of personal choice,

while public effects create a public right to intervene. In addition, for many utilitarians consensual acts between adults are considered private. For this reason, utilitarian writers have generally suppported a liberalizing "privatization" of sexual morality. However, it should be noted that such writers have not extended this liberty to sexual contacts between adults and children, and have usually supported the view that children's welfare is always a matter of public morality.

Despite this, we might well ask whether utilitarianism provides us with the best moral framework for an evaluation of child sexual abuse. From this point of view, the wrongness of child sexual abuse would require empirical evidence of harm in its result; in the absence of discoverable harm, prohibitions would rest on some determined age of consent. Let us put this second problem aside, since child sexual abuse affects a population with an average age of 10 years (Gagnon and Simon, 1970).

What are we to make of reports of relatively unharmed victims, such as those cited above, if we equate wrong with harm? With this question in mind, we can see the difficulty which utilitarianism may encounter in addressing the wrongness of child sexual abuse. Therefore, we believe that a purely utilitarian ethic is inadequate to an understanding of the moral problems raised by the treatment of child sexual abuse victims. However, on the positive side, we should apply utilitarian norms to the evaluation of response processes to which victims are subjected following reports of abuse. If our duty is to minimize harm to children, it would be irresponsible not to inquire into the effects of public intervention policies and even to ask whether cases might occur in which non-intervention would be less harmful than intervention (Schultz, 1980).

How can we resolve these problems? There are three approaches we might consider:

<u>Utilitarianism defended:</u> Refuse to accept the existence of unharmed victims by arguing that such harm is not easy to observe and that we must dig deeper. We might even argue that the victim who denies harm is even more harmed, as evidenced by the denial syndrome. However, this stubborn utilitarianism is both non-empirical and insensitive to the victim's right to respect.

Relativism: This is an issue which deserves fuller discussion. Relativism is the theory which denies that there are any objective facts upon which to base our value judgments. Morality is relative to public opinion, or in its most extreme version, morality is a matter of personal preference. In such a view, different cultures or different families treat their children differently and there are no universal or cross-cultural standards which establish uniform responsibilities for all. In the case of child sexual abuse relativism would argue that if it is wrong it is because enough people have decided to believe it wrong, thus setting a social norm. Likewise it is harmful, when it is, because of these same social perceptions and the sanctions which they carry. What would such an approach recommend? This is conjectural, but it would seem logical that relativism would advocate loosening those prohibitions which create the harmful consequences. This approach would no doubt place children at greater risk, should it prove wrong. But more importantly, by reducing moral restraints to elastic public opinion, relativism does injustice to the seriousness with which we view the problem. In addition, it raises the question of how to read the history of changing attitudes toward child sexual abuse. We want to say that there **is** progress and enlightenment here; relativism would say there is only changing opinion and a shift of attitude. Yet, as we will see below, relativism does provide a valuable, although limited, insight into one important treatment issue.

Mixed deontological approach. The approach we advocate is incomplete and developing. We refer to it as "mixed" and present three points which integrate the strengths of the rejected approaches under a basic deontological principle:

(i) **Respect for the personhood of the child should be seen as a moral absolute.** Child sexual abuse violates this principle by reducing the child to an object for sexual gratification in a relationship where the equality of parties is impossible, the possibility of meaningful consent highly dubious and where such a risk of physical and psychological abuse is present that no responsible adult could endorse it. To appreciate the strength of the moral intuition behind this view, ask yourself whether you could permit yourself to be so treated. To see the weakness of the utilitarian approach, ask whether you would say yes if trauma were eliminated. To see the weakness of relativism, ask whether you could advocate the elimination of all social norms governing the treatment of children by adults, or whether all norms could be equally acceptable.

(ii) We need, however, to retain a utilitarian perspective as self-critical practitioners in implementing this principle. In other words, **we have a duty always to minimize the harm which a child suffers** from abuse, and the iatrogenic harm suffered by children at the hands of those who seek to do right.

(iii) Finally, an element of relativism is necessary: **We must ensure that the child's opinions and perceptions of her victimization are respected.** Although we may have a better (or more developed) moral sense, we must proceed cautiously lest our own degree of condemnation of abuse create unnecessary pain for the victim in our care.

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